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AN

ADDRESS

ON

MINOR GYNÆCOLOGY.

BY

ARCHIBALD DONALD,

M.A., M.D., M.R.C.P.

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By Archibald Donald, M.A., M.D., M.R.C.P.

The choice of a subject for my address this afternoon caused me some little trouble, but I decided to follow the plan which is generally adopted on similar occasions, and to take the opportunity of reviewing the recent advances and changes in the practice of our special branch of medicine. It is well for us to pause now and again in order to take a general survey of our work, to note the changes which have crept into our practice, and to estimate as far as possible the comparative merits of the new over the old. This is a task, however, which is by no means easy, for even in scientific matters the weight of fashion is felt.

It is impossible in the course of one address to notice all the recent changes in gynæcology, and I propose to limit my remarks to some points in the treatment of the minor diseases of women. There is no lack of summaries and criticisms of new methods in the more serious gynæcological operations, but I think that recently there has been a tendency to say and to write comparatively little in regard to some of those less exciting ailments which constitute the bulk of our out-patient and consulting room practice. I propose therefore to direct your attention to some points on which I think our methods have changed in recent years, and in doing so will state some opinions. With these opinions, of course, I do not expect every one to agree; they must be taken merely as my interpretation of the tendency of our present practice.

Perhaps the best way for any of us to bring home the changes which have occurred is to compare the methods of treatment which were general when we commenced gynæcological work with those which are at present adopted. In my own case these periods of time are not separated by a very long interval, but in that interval there have been considerable changes, and I believe

much real progress has been made. If I were asked to summarise briefly the salient points in the out-patient practice of the early eighties, I should mention the following:—(1) The frequent use of pessaries; (2) the importance attached to the uterine sound, as an aid to diagnosis and as a means of treatment; (3) the common employment of chemical caustics and irritants in the treatment of cervical catarrh; and (4) the importance attached to the purely out-patient treatment of many gynæcological ailments. It is on these four points that I think the divergence of our present practice is most noticeable, and it is for that reason that I give them prominence. In any case they seem to me to be worthy of consideration.

The use of pessaries.—I believe that there has been within recent years a very marked diminution in the use of pessaries, at least by specialists. This is undoubtedly true as far as *anteversion and anteflexion* pessaries are concerned; in fact, they may be said to be entirely out of date. It was early recognised by the majority of specialists that no vaginal pessary could straighten an anteflexed uterus, and that any pressure which could act through the vagina upon an anteverted fundus must do so through the bladder, and was for that reason likely to be injurious. It is therefore unnecessary to discuss pessaries which were specially constructed for cases of anteversion and anteflexion. Some medical men still recommend a ring or a Hodge pessary in cases of anteversion with enlargement of the uterus, in the belief that the general lifting up of the uterus will relieve the the symptoms. This point will be referred to when we come to consider the use of pessaries for some cases of retroversion.

The diminution in the use of pessaries for *retroversion and retroflexion* has not been so marked, but I believe that in these displacements they are not used in hospital or consulting practice to the same extent as formerly. Even at the time that they were most in favour there were some gynæcologists who deprecated their use in such cases. The argument against their employment chiefly took the form of a general statement that the backward displacement of the

uterus gave rise to no trouble or discomfort, and, as cases were of frequent occurrence in which it seemed to be associated with distinct disturbance to health, this assertion was regarded by the majority of gynæcologists as much too sweeping. With an increased knowledge of the pathology of uterine disorders, we have, I think, gradually come to understand more fully the significance and results of a retroversion of the uterus. [I may here remark that I do not consider the distinction between retroversion and retroflexion to be of any practical importance, and that I use the term retroversion as including both]. The important point is to discriminate between the symptoms produced by the displacement *per se* and those which are caused by co-existing pathological conditions in the pelvis. In dealing with a case of retroversion it is well to consider the etiology o the condition. From this point of view two well-marked types may be recognised:—(1) Cases in which retroversion is due to purely mechanical causes; (2) cases in which there are certain pathological processes which have acted as predisposing causes of the displacement.

By a purely *mechanical retroversion* I mean the accidental dislocation in the backward direction of an otherwise normal uterus. If we wish to study the symptoms in this class of case it is well at first to exclude cases due to congenital defects, as these are apt to be complicated by symptoms of nervous or mental origin. We must exclude also cases occurring in married women, and cases in which attempts have been made to rectify the displacement by means of the uterine sound. Further, we must exclude cases in which the uterus is fixed or limited in mobility, or in which we can find some thickening which might indicate a previous attack of pelvic peritonitis. We have all had to deal with cases of purely accidental retroversion in which there is little doubt that the displacement has existed for some time without any symptom. Sometimes it has only been discovered more or less accidentally. In my opinion there is only one symptom caused by the retroversion of a healthy uterus; and that is not invariably present, namely, a sense of

weakness, we can hardly call it a pain, in one or other, or in both, iliac regions. It is probably due to the stretching of the round ligament caused by the dragging of the fundus of the uterus. The question, however, arises as to the possibility of secondary changes being set up in the uterus as a result of the displacement. Some years ago Dr. Sinclair drew my attention to a point which I have often since observed, namely, that in cases of old standing retroversion there is marked hypertrophy of the posterior, as compared with the anterior lip of the cervix. But I believe that this comparative thickening is more apparent than real. The backward tilting of a heavy uterus causes the upward lifting of the anterior lip of the cervix so that the anterior fornix is obliterated and the anterior lip of the cervix does not project so far into the vagina as in the normal position. If the uterus be straightened by pulling the cervix down with a vulsellum it will generally be found that there is no marked difference in the size of the two lips. I have never found that symptom in unmarried women and I think that evidence is yet wanting that the mere backward displacement of the uterus is the cause of pathological change either in the mucous membrane or in the muscular wall.

If the opinions above expressed are correct, it follows that the treatment by pessaries in cases of simple accidental retroversion is injudicious, as the inconvenience caused by the displacement is so slight that relief from it is dearly purchased at the cost of wearing a pessary. It is my conviction that we are apt to underrate the harm caused by pessaries. I am not now referring to exaggerated cases of abuse, such as serious ulcerations caused by long retention and final incarceration of the pessary. Even what is called a "well-fitting" pessary is not harmless. There is always a liability to irritation of the vaginal mucous membrane and to increased secretion, and this involves the regular use of the vaginal douche. I have heard a good many complaints on this score from women who have been induced to wear a pessary for some time but who have ultimately discarded it in disgust. There is, further, a liability to pressure on the rectum

and I have seen many cases in which constipation was always troublesome when the pessary was *in situ*, and disappeared when it was withdrawn. Finally, it is hardly necessary to say that much injury may be done to a neurotic patient by attracting her attention to slight ailments in the pelvis; and this is just what the treatment by pessaries does.

Before leaving the subject of accidental retroversion, we may note that some of these cases are associated with a minor degree of prolapse, or, more correctly, the retroversion is merely the first stage of a prolapse. The treatment to be adopted depends entirely on the degree of prolapse.

Pathological retroversion includes cases in which there is some enlargement of the womb, or some disease either of the womb itself, or of surrounding structures. The enlargement may be due to pregnancy, to fibroid tumour, or to subinvolution. The diseases which are most commonly found complicating retroversion are endometritis and pelvic peritonitis. Any increase in weight of the body of the uterus exaggerates the purely mechanical symptoms of a retroversion. Thus, in early retroversion of a gravid uterus the characteristic pain in the iliac regions is increased. The same remark applies to retroversion associated with fibroid tumour or chronic metritis, but the symptoms are no longer purely those of retroversion of a heavy uterus; the symptoms of fibroid tumour or subinvolution are supperadded. If a fibroid is found in a retroverted uterus there is generally no confusion of symptoms in our minds; if menorrhagia or leucorrhœa are present they are regarded as symptoms of the fibroid, and not as results of the displacement. But when the uterus is enlarged by chronic metritis and is at the same time retroverted, the tendency has been to regard all the symptoms as being caused by the displacement. In retroversion associated with chronic metritis the symptoms usually found are:—(1) dragging pains in the iliac regions and backache, and (2) menorrhagia or metrorrhagia and leucorrhœa. The latter symptoms are caused by the chronic metritis, and not by the displacement; we find them just as well marked in cases of

chronic metritis associated with anteversion. The usual history of these cases begins with a confinement or an abortion, and I think the name of "chronic infected case," which Hart applies to them is a very good one. There is first puerperal endometritis, then there is arrest of involution, and the heavy uterus may, or may not, become retroverted. If the infection is a little more acute, the pathological processes extend to the uterine appendages and pelvic peritoneum, and the uterus may eventually be bound down in a position of retroversion. In this case, at least in the earlier stages, we have all the symptoms already mentioned, and in addition there is generally some dysmenorrhœa. Pessaries are quite unsuitable in all these cases. We cannot cure chronic metritis or chronic pelvic peritonitis by means of a pessary, in fact it is apt to do more harm than good. The obvious course to adopt is to do what we can for the inflammatory condition in the first instance. If we succeed in reducing the size of the uterus, or in procuring absorption of inflammatory exudations or adhesions, most of the patient's troubles will disappear. I have heard it claimed that the symptoms in cases like these are alleviated by means of a pessary, that the mere raising up of the heavy uterus (and this applies to cases of anteversion) will relieve the congestion and make the patient more comfortable. I do not deny that the pessary may have some effect in relieving the dragging or bearing-down pain and the backache, but I have never been able to convince myself that it has the slightest influence on any pathological changes which may exist in the uterine mucosa or muscular wall. It is not within the scope of my remarks to-night to dwell on the means best calculated to cure these pathological changes. It is sufficient to say that many cases are greatly improved by palliative measures, such as, absolute rest for some weeks, the use of the hot vaginal douche and general medical treatment; and that in many cases in which the changes are more advanced thorough dilatation and curetting of the uterus is followed by marked amelioration of the symptoms and by actual diminution in the size of the uterus. When chronic pelvic peritonitis with

adhesions exists, the choice lies between the palliative measures above referred to and operative procedure.

For cases of *prolapse of the uterus* pessaries are used in much the same proportion as formerly. I think some of the more complicated kinds, such as the Zwanecke, have almost entirely disappeared, and we now trust mostly to ring pessaries, and the cup and stem with external supports. In the more advanced degrees of prolapse operative treatment is more common than it was.

We may, I think, sum up the changes which have taken place in the use of pessaries during the last fifteen years as follows:—1. Pessaries for anteflexion and anteversion, and the more fantastic kinds of pessary generally, have disappeared, or are disappearing. 2. Simple retroversion in nulliparous women is not so frequently treated by means of pessaries. 3. More attention is now paid to the complications of uterine displacement.

The uterine sound.—The discovery of the uterine sound was regarded as a great step towards accurate diagnosis. For a long time this instrument was looked upon as one of the chief aids to gynæcological diagnosis, and even in the text books of to-day much importance is attached to its use. My own opinion is that if the good and evil which have resulted from its use and abuse could be weighed, the balance would be found on the wrong side. The help it gives us is not very great, and it has undoubtedly been often wrongly employed. It is useful in the diagnosis of stenosis of the cervical canal, and it occasionally helps us to distinguish uterine tumours from those arising in other pelvic organs, although in the latter kind of case a careful bi-manual (if necessary under an anæsthetic) will generally give us all the information we require. As an instrument to be carried about in the pocket for use in nearly every gynæcological case it must be condemned. I think it is now much more rarely employed in this way than it was formerly. Its place is in the operating theatre, rather than on the consulting room table. No doubt the evils which follow upon its use are nearly

always to be attributed to the want of sufficient care in disinfection; but the operation of passing it is so simple that aseptic precautions are apt to be neglected. I have known several cases of acute pelvic peritonitis which were caused by the use of the sound, and I have seen many instances of chronic pelvic inflammation which I had reason to believe were traceable to the same origin. The history that we obtain of these cases often runs something like this:—To begin with there was some minor discomfort in the pelvis or abdomen; a vaginal examination was made and a displacement discovered. The displacement was put right by means of an "instrument" which caused a good deal of pain, and a pessary was introduced. Then a new class of symptoms appeared: there was persistent backache and increased pelvic discomfort with marked affection of the general health. On examination we find a retroverted uterus firmly bound down by adhesions, and all the signs of chronic pelvic peritonitis. In searching for the cause of this condition, if we can exclude childbirth and abortion, we are compelled to regard the case as one of traumatic septic origin, and the uterine sound as the probable means of infection.

The use of the sound for the purpose of replacing a retroverted uterus is, to my mind, a procedure which is unscientific. We cannot know exactly what we are doing when we force the uterus into position by means of the sound. If the uterus is mobile and we think it necessary to reduce it, we can often do so by means of the fingers. If it cannot be replaced in this way the patient should be examined under an anæsthetic so that we can make sure that there are no adhesions or thickenings in the neighbourhood of the uterus.

Applications to the cervix and endometrium.—Applications to the cervix were still employed in the early part of the period of which I am speaking, but they were not so popular as in the previous decade.

Cervical erosions were not uncommonly treated with chemical caustics and irritants, such as nitrate of silver, carbolic acid,

tincture and liniment of iodine, etc. Sticks of nitrate of silver and other escharotics were introduced into the the cervical canal. Tampons of cotton wool soaked in various astringents and sedatives were often inserted into the vagina in cases of catarrhal affections of the uterus. From my own observation and from the lack of any recent reference in print to these chemical agents, I infer that they are almost, if not quite, entirely given up. No doubt, strong escharotics, such as chloride of zinc, may be still at times be employed in cases of advanced malignant growth, but even for these cases the thermo-cautery is generally preferred. In acute or chronic pelvic inflammation glycerine tampons are still employed, but only when the patient is kept in bed, and I think we hardly attach so much importance to them as we did. The application of ichthyol in this way in cases of inflammatory mischief and of gonorrhœal infection has many supporters. The use of strong caustics to the cervix involves the risk of causing cicatricial stenosis of the cervical canal. It is only a few weeks that I saw a patient who had been treated by repeated applications of pure carbolic acid to the cervix, and in whom, as a result of the treatment, the cervical canal was so narrowed that it would not admit a small probe. Further disadvantages are that the treatment has to be frequently repeated, and it is uncertain in its action. This is expressly stated by a late well-known gynæcologist, who himself adopted the treatment. Speaking of chronic cervical catarrh, he says "The ordinary treatment is the cauterization, by nitrate of silver, of the diseased surfaces. The stick is to be passed into the cervix and turned round. This may be repeated every third or fourth day for several times. It is not the most successful treatment. Many cases do not yield to it; and frequently the practitioner perseveres with its use. not only long after it has ceased to be useful, but when it becomes positively injurious. I have known this kind of treatment continued for years. Long before such a period has elapsed, indeed after several—say about ten—applications at most in ordinary circumstances the practitioner should have the case cured, or give it up as not amenable to the

treatment." In the next paragraph the author recommends that a stick of zinc alum should be passed into the cervical canal. For the severest cases with hypertrophy and a nodular condition of the cervix he advises the use of stronger caustics. The book containing these remarks was published in 1883. I can scarcely imagine that there is any gynæcologist at the present time who is in the habit of treating cases of cervical catarrh in the above manner. In the severest cases referred to the usual practice is to excise the diseased and degenerated tissues. The knife is a simpler, safer, and more certain means or removing tissue than any caustic. The less severe cases of cervical catarrh may, I think, be regarded as part of a general endometritis, and if local treatment is required at all, it must be such as will influence the endometrium as well as the cervical mucous membrane. In such cases the curette has largely, if not entirely, taken the place of sticks of caustic. There is no more striking change in recent minor gynæcology than the extraordinary increase in the use of the curette. In looking over the Medical Reports of St. Mary's Hospital, Manchester, I find that in 1887 curetting was performed three times, in 1888, eight times, while in 1899 there were 113 cases of curetting out of a total of 461 operations. This experience I believe is not peculiar to the hospital mentioned. The operation was formerly only performed in cases of recent abortion or for diagnostic purposes, now it is the treatment most generally adopted in well-marked cases of endometritis. There can be no question in the minds of those who have frequently tried it as to its efficacy in suitable cases. It nearly always checks the excessive menstrual flow and the leucorrhœa which are frequent symptoms of endometritis; it renders pregnancy more likely to occur and abortion less likely; it is often followed by involution in cases of chronic metritis; and it is sometimes the starting point of absorptive changes in inflammatory exudations and adhesions in the neighbourhood of the uterus. But like every other useful remedy it is capable of abuse, and I think it is time we asked ourselves if it is not being practised rather indiscriminately. The danger of over-doing it

is found, I believe, in two classes of cases:—In the mild type of endometritis which calls for no local treatment; and in acute septic post-partum mischief, in which, in my opinion, the benefits of the operation are sometimes overrated, and its risks under-estimated. Further, it must always be remembered that although the operation, if carefully performed, is in itself practically free from danger, it should be hedged round with the most scrupulous asepsis. If this precaution is neglected we are likely to do more harm than good.

The "out-patient" treatment of gynæcological ailments.—From what I have already stated in the three preceding sections of this paper, it is evident that the present tendency of minor gynæcology (in my opinion at least) is to abandon a good many of the manipulations which were formerly so common in the out-patient and consulting room. The uselessness of out-patient treatment in the large majority of cases must be apparent to all who have had much of this work to do. In expressing this opinion I am referring only to treatment, and not to the diagnosis or the observation of the progress of cases, which must of necessity be largely conducted in the out-patient or consulting room. The present attitude in regard to minor gynæcological ailments is to avoid local interference as far as possible, but when local treatment is decided to be necessary to carry it out at one sitting. Both in major and minor gynæcology our methods have been simplified. There is less "meddling and muddling" than there was, and the methods of treatment are less special. We still fully recognise the curative effect of absolute rest in many of the diseases of women. When the extent or nature of the local mischief is obscure we have more frequent recourse to an examination under an anæsthetic than formerly. When local measures are undertaken they are more akin to those which are used in general surgery. I suppose that the beginnings of most "specialities" are usually associated with methods of treatment which are strange and complex. Such has certainly been the case in gynæcology. Much

mechanical ingennity has been wasted in the invention of instruments and apparatus which have since proved quite unnecessary. The écraseur, the galvano-caustic wire, the uterine elevators and metrotomes, the intra-uterine stem, the special kinds of scissors, the complicated clamps and trocars; all these were in use at the time I started practice, and all are now swept away. Our equipment now differs little (save in the matter of vaginal specula) from that of the general surgeon.

In concluding my remarks I have to repeat what I said at the beginning. I am fully conscious that there are many who will disagree not only with my interpretation of the way that matters gynæcological are tending, but also with the opinions as to treatment which I have allowed myself to express. In no department of medicine are there greater divergences of opinion than are to be found in the department of gynæcology. This is largely owing to the fact that gynæcology is the study of diseases peculiar to women. By this apparent truism I mean that we gynæcologists have to deal with a sex which is, rightly or wrongly, supposed to be especially liable to disturbances of a neurotic or hysterical nature. To draw the line rightly between symptoms which are the result of organic disease and those which are merely the outcome of a disturbance of nerve function, is a task which, in our present state of knowledge, is at all times difficult, and frequently impossible. Small wonder then if we differ as to the boundary. In our own ranks we find men equally sincere who hold opinions utterly opposed. Both extremes of opinions are, to my way of thinking, wrong, and both may if carried into practice do much harm. The dangers of over-operation are plain and have been insisted upon in an address which was delivered on an important occasion and published not very long ago. But it is not less true that we may fail to relieve much suffering if we shut our eyes to many of the consequences of the minor gynæcological ailments. It must be our endeavour to free our minds from prejudice as far as possible, in order that we may arrive at conclusions which will bear the test of time.